CECANF DRAFT REPORT

EMERGING THEMES AND RECOMMENDATIONS
DRAFT 7.3

Based on information obtained from one year of public hearings, meetings, and site visits, and a review of many research, practice, and policy documents, the Commission believes that deaths from child abuse and neglect are preventable. There is not yet scientific evidence to support which specific strategies will eliminate these deaths, but through testimony and reports of promising efforts in several communities around the country, a number of themes and recommendations have emerged.

THEME #1 – FATALITIES ARE PREVENTABLE WHEN COMMUNITIES COME TOGETHER WITH PUBLIC AGENCY LEADERSHIP ON BEHALF OF CHILDREN AND FAMILIES.

The problem of child abuse and neglect fatalities is solvable when a broad array of public systems and community partners come together in a coordinated way on behalf of children and families. In successful efforts, the prevention of child abuse and neglect fatalities is a central concern that guides the provision of all child and family services. Such efforts include capable and effective child protective services (CPS) agencies, but also extend to other public and private entities that come together to form a safety net. Some of the most promising efforts that we have seen thus far involve cross-system engagement, integration, and communication with law enforcement, medicine, public health, mental health, domestic violence, substance abuse, and the judiciary. Other critical partners have included education, early education, child care, elected officials, legislators, the media, family and community members, and the broader public.

Successful community-wide partnerships to reduce child abuse and neglect fatalities share characteristics of strong leadership and a collective sense of urgency. In communities that have developed successful efforts (Wichita, Salt River Pima/Maricopa, and others), there was a public recognition that child abuse and neglect fatalities are a critical problem that requires a comprehensive approach. Leaders from different systems and the community spoke up and prioritized solutions to identify and overcome barriers. Enhanced communication, shared goals, and accountability across diverse systems and stakeholders were other critical elements.

1-1 **CPS SC RECOMMENDATION:** Create national and sustained leadership and incentives to move state/local/tribal agencies (in addition to CPS) to prioritize child safety as a critical part of their mission.

Federal role: Provide leadership at the federal level.

State/local role: Provide leadership at the state and local levels.

1-2 **PH SC RECOMMENDATION:** Enable more flexible funding and place-based strategies to better integrate and align cross-system efforts. These could include:

- Dual-generation funding strategies to identify how Medicaid could fund services (e.g., mental health treatment, substance abuse screening and treatment) for the parent or parent and child together under the child's health care coverage
- Grant opportunities to enable funding innovation and braiding funding streams that make grantees accountable for outcomes, while permitting them to identify the federal and nonfederal flexibilities and funding blend needed to implement the strategies
- Grants that incorporate place-based strategies that build community capacity and help strengthen the safety net for families and children at risk of abuse and neglect fatalities

1-3 **CPS SC RECOMMENDATION:** Congress should authorize funding to support a multidisciplinary initial CPS response to child abuse and neglect reports. A nurse, substance abuse specialist, mental health specialist, domestic violence specialist, or other professional as appropriate should accompany child protection investigators on the initial response to a report of child abuse and neglect.

Federal role: Legislative action by Congress would be needed. Legislation could potentially include new federal costs due to an expansion of professional participants in CPS response/investigation of abuse and neglect reports. Upon passage by Congress, administrative action would be taken by the Department of Health and Human Services (HHS). Multiple agencies (ACF/SAMSHA/others) would have a role in providing state agencies with guidance/regulations. Agencies could take a variety of steps to ensure quality implementation, such as coordination of technical assistance to states, facilitating training, producing reports/toolkits, etc.

State/local role: State legislatures may enact enabling legislation and or other related legislation, including budget-related measures. State administrative agencies would have a role in implementing new policies and practices, including making updates to administrative code and policy manuals, conducting necessary trainings for staff and providers, etc.

1-4 **CPS SC RECOMMENDATION:** Congress should authorize demonstration projects involving multidisciplinary review of cases in which serious harm or endangerment has occurred. These reviews could be coordinated by children's advocacy centers (CACs) or similarly established local entities, through teams consisting of CPS, law enforcement, the district attorney's office, health care, mental health, substance abuse, domestic violence, and other disciplines as deemed necessary. Memoranda of understanding should exist for all parties. The population of cases would include but not be limited to cases with a history of violence in the household, caregiver felony arrests involving dangerous behaviors, children ages 0-5, gross neglect, an unrelated male living in the household, and families that have been the subject of more than one report. (*Note: Commissioner Martin raised questions as to the need to know when an MDT is triggered. The recommendation includes types of cases. Do you want to further refine this within the recommendation*?)

Federal role: Congress creates authorizing legislation, HHS administers grants to states and provides guidance and technical assistance (such as providing examples of MOUs).

State/local role: Broaden the role of CACs, create policy and procedural guidance, and provide general fund support to match federal funding.

THEME #2 – UPSTREAM PREVENTION ALLOWS SYSTEMS TO REACH FAMILIES BEFORE A CRISIS OCCURS.

The problem of child abuse and neglect fatalities is best addressed by a system that is proactive and preventive. Fatalities have not been reduced simply by improving the mechanisms that are already in place for CPS to investigate allegations of abuse or neglect. Upstream, population-based interventions focusing on the most at-risk subgroups enables systems to reach families before a crisis occurs that requires CPS intervention.

2-1 **PH SC RECOMMENDATION:** States should be required to develop and implement a comprehensive state plan to prevent child maltreatment fatalities. These plans should take a cross-system preventive approach, with CPS as one of multiple key partners—health and public health must be at the table. In testimony and in conversation with federal partners, it became clear that no state had a coordinated, integrated, family-centered, comprehensive maltreatment fatality prevention plan. These plans are seen as a cornerstone strategy by which to drive upstream prevention, and the Commission seeks to catalyze this effort. Federal legislation should provide guidance to states on core outcomes to be achieved, but states should have flexibility in their approach.

Federal role: Creating a coordinated, cross-system plan would entail federal legislative changes to grant the necessary authority and flexibility to support states in developing the plans. Federal oversight could be required to ensure the plans are effectively developed and implemented. One or more federal agencies may provide technical assistance. Congress may request reports from federal agencies as to the outcomes generated by the plan.

State/local role: State legislatures may need to enact enabling legislation and/or make budgetary allocations to support the programs and services covered by the plan. State programmatic leaders will need to coordinate and collaborate on the development and implementation of the plan and may need to develop memoranda of understanding to support their collaborations. Agency officials may want to engage community participants in planning or overseeing the plan.

2-2 **PH SC RECOMMENDATION:** Leverage opportunities in different public systems to improve the identification of children and families at risk. Many children who die due to abuse and neglect were not known to CPS before they died. However, most of these children, especially those under age 4, were known to other systems, particularly health care. This recommendation seeks to take advantage of these children and families' contact with the health care system and other service systems (e.g., drug treatment, early childhood, mental health). We also aim to leverage opportunities opened up by the Affordable Care Act. Our targeted recommendations may include: (1) utilizing health information exchanges to identify red flags; (2) developing new pediatric quality measures; (3) improving screening at visits for prenatal care, well-child care, and

emergency department services; and (4) ensuring behavioral health is part of Early and Periodic Screening, Diagnosis, & Treatment assessments.

Federal role: The Department of Health and Human Services issues guidance/technical assistance to state health agencies. HHS could issue guidance and TA that helps state agencies learn about research on brain development and the impacts of trauma, particularly research on the importance of addressing parent skill-building efforts and strengthening executive functioning. HHS also could showcase/disseminate examples of state leadership in each of the four areas mentioned in this recommendation.

2-3 **PH SC RECOMMENDATION:** Ensure access to high-quality prevention and intervention services. With the identification of children and families in need of greater support, a spectrum of high-quality services and supports should be accessible to support families' needs and identified risks. This must begin further upstream. Where appropriate, families should be seen as the unit of intervention, and services must address parental needs, including substance abuse, mental health challenges, housing and other basic needs, and domestic violence. These efforts should build upon research on brain development and the impacts of trauma, particularly research on the importance of addressing parent skill-building efforts and strengthening executive functioning. Child care, home visiting, and parent skill building will be included among the recommended prevention strategies.

THEME #3 – OVERSIGHT AND ACCOUNTABILITY ARE LACKING.

Enforcement of federal child welfare policy—and oversight and accountability around the issue of child abuse and neglect fatalities at all levels of government—are limited. Federal child welfare policy makes clear that the safety of children is a paramount concern. Congress and state legislatures have enacted a range of policies to help ensure the safety and health of children who are at greatest risk of harm. Yet, a close examination of safety-related policies reveals inconsistent implementation among the states and a lack of enforcement at the federal level.

3-1 **CPS SC RECOMMENDATION:** The federal government should have a full range of authority needed to ensure state compliance with federal policy and law, up to and including legal action.

Federal role: Through Congress (or through administrative rule-making), create a legal basis for a federal role in child abuse and neglect death cases that call into question the performance of state and local child protection agencies. Require necessary reporting by states, including submission of all necessary records, to the designated federal entity.

3-2 **CPS SC RECOMMENDATION:** CPS agencies should have quality assurance (QA) plans for the timely review of practices critical to maintaining child safety and the ability to provide immediate feedback and make case adjustments as necessary.

Federal role: Provide leadership in the identification of safety-critical practices. Provide funding to support innovations in real-time QA and feedback about such practices.

State/local role: Implement expanded QA that focuses on critical safety practices.

3-3 **CPS SC RECOMMENDATION:** The Administration for Children and Families (ACF) and states should work together to identify standards for case supervisory and management oversight of practices critical to child safety.

Federal role: Provide leadership and facilitation.

State/local role: Implement enhanced standards.

3-4 **MEASUREMENT SC RECOMMENDATION:** Consolidate federal responsibility and leadership into one federal agency to provide oversight, leadership, and guidance in development of child maltreatment fatality investigation and surveillance/measurement systems, including building a public health child maltreatment fatalities registry and expanding and standardizing reporting of fatalities into NCANDS.

THEME #4 – CURRENT SAFETY AND RISK ASSESSMENT PRACTICES ARE INADEQUATE.

Safety and risk are dynamic qualities of a child and family's life. Currently, CPS agencies are principally designed to respond to specific allegations involving specific children. A significant percentage of fatally maltreated babies and young children who have prior contact with CPS have been the subject of more than one, sometimes several, CPS reports. Investigators commonly assess the immediate safety factors around an incident that led to a report (present danger) and may not always take into account past history or broader family risk factors that may not be associated with the current allegation (e.g., a previous death of a child in the family or previous allegations of abuse or neglect, violence or violent individuals present in the home, multiple reports of domestic violence). This leads to a point-in-time approach to a child's safety that may not always fully consider a child's history and impending danger for fatal maltreatment. The issue of impending danger is critical because many of the families in which child abuse and neglect fatalities occur have been the subject of previous allegations of abuse or neglect—though not always specific to the child who died. At the time of the previous allegations, most of these children were initially judged to be safe (and probably were, at that point in time). Further, we know that decisions about child safety are frequently made by CPS caseworkers in isolation and based on incomplete information.

4-1 **CPS SC RECOMMENDATION:** States should adopt broader statutory language and protocols on "threat of harm" when establishing a threshold for a CPS response, even though abuse or neglect may not be currently evident. The federal government should take a leadership role in developing model legislation, policy, and practice guidelines.

Federal role: Develop model legislative language.

4-2 **CPS SC RECOMMENDATION**: Congress should authorize funding for multidisciplinary retro reviews of cases based on a profile of children who have been seriously harmed or died in the state (similar to the Rapid Safety Feedback methodology used in Hillsborough County Florida). States would be responsible for the administration of these reviews, with HHS playing an oversight role. The reviews would be voluntary and provide an opportunity to demonstrate, test, or model sharper intervention in high-risk situations. States offering the opportunity for a control group would be a priority.

Federal role: Create enabling legislation and funding. Provide technical assistance to support transfer and implementation.

State/local role: Staff, organize and fiscally support the reviews. Prepare reports on findings from the reviews.

4-3 **RESEARCH RECOMMENDATION**: Develop standardized ways to measure severity of harm, severity of risk, and severity of maltreatment to an individual child and to the family/other children in the home. Develop tools to support decision-making at all touch points of the CPS system. This recommendation includes the use of predictive analytics. The term *decision-making* is used broadly and could refer to decision-making about in-home services, safety assessment, long-term reunification goals, etc.

Specific recommendations within this broader recommendation include the following:

- Evaluate whether there is a broader way to communicate information than a single risk score—could relevant case examples be used as a way to educate and reinforce decision-making?
- Develop and validate a risk score that could be assigned at the time of the initial call to CPS (triage). This risk score would, ideally, be a quantitative measure of risk that could impact decisions about whether to screen in or out cases and/or how to respond to reports.
- Develop and validate a severity index that could be used to assess safety at the time of the initial evaluation by a CPS caseworker and at subsequent points in the progression of a case.
- Evaluate the use of triage points other than child welfare (e.g., when a parent is referred for mental health treatment, when a new adult moves into the home, when an adult with a prior history of abusing a child has another child, etc.) for risk assessment.
- Study the roles of different societal agencies in identifying risk for child abuse and neglect fatalities and integrating risk into their intervention models (e.g., move away from a model of a single intervention for all clients and toward a system that targets specific interventions to specific clients at specific times).

Suggestions for how to carry out these recommendations using existing data include the following:

- Apply a predictive model retrospectively to 5-10 years of data on all cases, to categorize severity and then see what the severity index would have been for those cases that eventually became fatalities and near fatalities. Researchers could first assess the investigative data and then the entire case, to see at what point the index shifts and whether the use of the index would have value in the future.
- Use data from a process such as the Pennsylvania Quality Service Reviews, which randomly select cases to be reviewed by two-person teams who interview everyone connected with the case. Given that these cases are already pulled for review, it might be possible to use them to illuminate the risk score/severity index that is retrospectively applied to each.

THEME #5 – THERE ARE KNOWN RISK FACTORS FOR CHILDREN WHO DIE FROM ABUSE AND NEGLECT.

Research has identified characteristics of the children who are most at risk. Through data analysis and testimony from experts, we have learned which children are at greatest risk of dying from child abuse and neglect. The single biggest risk factor is age—close to half of all deaths are to infants, and almost 80 percent of the children who die from maltreatment are less than 4 years old. Another very significant risk is a prior report for child maltreatment before the age of 5 to CPS, whether the report is substantiated or not. Family risk factors include poor parental attachment, poor impulse control, and resistance to CPS involvement and intervention. Other family risk factors include young parents, substance use, domestic violence, and mental illness. Community-level risk factors include social isolation and lack of access to services. Research also indicates that children who die from maltreatment are likely to live in homes with many people, including nonfamily members. Caretakers, particularly biological parents, are the most common perpetrators of fatalities. Deaths among American Indian/Alaska Native (AI/AN) and African-American children are overrepresented in counts of child maltreatment fatalities, compared to these groups' proportion of the nation's child population.

5-1 **CPS SC RECOMMENDATION**: The child protection system should ensure a priority response to children ages 0-5—the group of children most at risk for a child abuse or neglect fatality. Responses should incorporate a developmental and trauma-informed approach.

Federal role: Provide guidance and technical assistance.

State/local role: Implement appropriate responses.

5-2 **CPS SC RECOMMENDATION:** Prioritize prevention and support services to prevent and address abuse and neglect by young parents who live in the child welfare and juvenile justice systems (who have many of the risk factors, and whom we have responsibility for and full access to).

Federal role: Remove barriers to prioritizing populations.

State/local role: Target the most at-risk populations for immediate access to critical services.

THEME #6 – STUDY OF NEAR FATALITIES CAN PROVIDE FURTHER INSIGHT.

The study of near-fatal maltreatment incidents can provide valuable insight that may help prevent deaths from child abuse and neglect. Children who nearly die from abuse and neglect share many of the same individual, family, and community characteristics as are present in fatalities. This group of children is much larger than the group of children who die, although we don't have precise data due to the lack of a consistent definition of what constitutes a near fatality.

NO RECOMMENDATIONS YET

[See 10-2, 7-2 for possible recommendations under this theme.]

THEME #7 – DIFFERENT TYPES OF FATALITIES REQUIRE DIFFERENT INTERVENTIONS.

Child abuse and neglect fatalities do not follow a single, simple pattern. Circumstances of these deaths encompass a variety of forms of abuse and neglect; therefore, different types of interventions are needed to prevent the different types of fatalities. Without a reliable and consistent classification system, it is difficult to develop and test specific strategies and interventions to prevent each type of fatality.

7-1 MEASUREMENT AND CPS SC RECOMMENDATION: Improve the understanding and counting of child maltreatment fatalities and near fatalities by rapidly developing a standardized classification system. This will entail establishing a uniform national definition of and standard of proof for a child abuse and neglect fatality for reporting purposes, as well as better differentiation of fatalities for intervention.

Federal role: Provide leadership in the design of the classification system.

State/local role: Implement the classification system and report data as defined.

7-2 RESEARCH RECOMMENDATION: Develop a typology of fatalities, each with its own risk factors, intervention strategies, outcomes, etc., and delineate societal from family from individual characteristics for each type of fatality.

To complete this recommendation:

- **Develop a standard set of data elements that is collected on all fatalities and near fatalities.** There are currently multiple data systems that collect data about fatalities, including the National Child Abuse and Neglect Data System (NCANDS), the Child Death Review Case Reporting System (CDR-CRS), the National Violent Death Reporting System (NVDRS), the Sudden Unexpected Infant Death (SUID) Case Registry, etc. These systems do not contain the same data elements and currently cannot share data. Very few data are collected systematically about near fatalities at the local/state or national level. It is important to create a fatality/near fatality file within NCANDS and to link CDR-CRS with other data sources.
- **Develop working definitions of *child abuse and neglect fatality* and *near fatality*.** A public health definition of *fatality* and *near fatality* will be most useful for research purposes, but there may need to be multiple definitions for different entities, including police and CPS. Reliability and validity of definitions are important; reliability (consistency over time) is more critical than validity (getting precisely the right number). Clear criteria for reconciling multiple data sources will be an essential part of developing and validating definitions.

THEME #8 – THE POTENTIAL FOR SHARING CASE-LEVEL INFORMATION ACROSS AGENCIES TO IMPROVE CHILDREN'S SAFETY HAS NOT BEEN FULLY REALIZED.

Sharing information across public agencies is permitted by law in most cases and could improve our ability to prevent child abuse and neglect fatalities. Multiple actors across public agencies often have interactions with the same families in which children are at risk for child abuse and neglect fatalities. From health services to public benefits to law enforcement to CPS, there are a variety of opportunities where different agents can make observations and potentially connect pieces of information to guide actions that could better serve families and protect children. Further, the ability to access information from other state and local agencies is sometimes imperative to determine the safety of a child. Families move from one state to another, children are adopted across state lines, and foster parent applicants have not always lived in one place. There are both real and perceived barriers to these types of information sharing between agencies, in real time, for the purpose of assessing safety and ensuring effective prevention and intervention strategies.

8-1 **CPS SC RECOMMENDATION:** Eliminate barriers to collaboration and sharing of information across agencies that would allow effective safety investigations. ACF must evaluate data sets that need to be linked and work to ensure interoperability as needed to save children's lives.

Federal role: Identify barriers, identify necessary data elements, and provide fiscal support for data integration efforts.

State/local role: Integrate data sets.

8-2 **CPS SC RECOMMENDATION:** Base confidentiality restrictions regarding sharing of information on what is needed to ensure child safety once children are referred to CPS.

Federal role: Examine federal legislation, rules, and regulations that inhibit data sharing. Remove barriers as needed.

State/local role: Share data as needed.

8-3 **CPS SC RECOMMENDATION:** Create more efficient mechanisms to share information between jurisdictions, as families are mobile and often move as a strategy to avoid CPS supervision.

8-4 **CPS SC RECOMMENDATION:** Cross-reporting of all allegations of child abuse should be mandatory between law enforcement and CPS. Joint investigations should follow protocols established jointly by CPS, police, and prosecutors. Further, jurisdictions should adopt and implement Electronic Suspected Child Abuse Reporting Systems (ESCARS) such as the one developed in Los Angeles County that provides immediate notification to law enforcement for all abuse allegations.

Federal role: Provide enabling funding to support transfer and implementation of ESCARS.

State/local role: Mandate cross-reporting in state legislation.

8-5 **RESEARCH RECOMMENDATION:** Link multiple data sources in a way that is standardized, available for research (and ultimately practice), and continual (not a single linkage at one point in time with no ability to update). These linkages would need to include not just CPS data but also data from birth records, death records, Medicaid, and others. Because fatalities and near fatalities overwhelmingly occur among very young children who often have not had contact with CPS themselves, linkage to non-CPS sources, as well as linkage by family, will be critical to decrease/eliminate child abuse and neglect fatalities and near fatalities.

Inclusion of all investigated cases (vs. only substantiated cases) will be critical. States should be able to retain rather than expunge data from nonindicated cases so that the data can be used for research.

Suggestions for implementation:

Perform a multistate evaluation of the impact of efforts to link birth data to child welfare data—specifically, data linked to cases that have prior termination of parental rights, guardianships, near fatalities, or criminal conduct related to child abuse. This may help to identify which combinations of birth factors and maternal risk factors (e.g., number of prior births to the mother, birth weight of the child, maternal smoking) would be most helpful in identifying children most at risk for subsequent child abuse and neglect fatalities.

THEME #9 – THE NATIONAL COUNT IS INCONSISTENT AND INACCURATE.

States vary tremendously in how they define and measure child abuse and neglect fatalities. There is widespread agreement that these measurement and definitional inconsistences result in a significant undercount of the number of deaths. In addition, these inconsistencies impede our ability to understand the circumstances of the deaths. High-quality and integrated data are essential to inform a comprehensive strategy for prevention and assess its results. Findings from state-level meetings and extensive input from experts confirm a lack of consistency in how national measurements of child abuse and neglect fatalities are conducted, in part due to the variety of definitions and methods employed by states and localities for determining whether a fatality is due to abuse and neglect. These deficiencies are particularly striking in cases of neglect fatalities, which make up the majority of all child maltreatment deaths. As a result, we do not have a reliable source to determine how many children die from abuse and neglect. Each national system (e.g., NCANDS, Vital Statistics/Death Certificates, FBI Uniform Crime Reports, CDR-CRS, NVDRS) contains valuable but incomplete information on abuse and neglect fatalities.

9-1 **MEASUREMENT SC RECOMMENDATION:** Define the purpose of counting fatalities as preventing child abuse and neglect fatalities through identification of successful interventions for specific types of fatalities, identification of necessary policy changes, and determination of culpability as appropriate.

9-2 **MEASUREMENT SC RECOMMENDATION**: Build a public health child maltreatment fatalities registry and expand/standardize fatalities reporting into NCANDS.

9-3 **MEASUREMENT SC RECOMMENDATION:** Improve the system of child death investigation and death certification by developing standards for investigation and resourcing of expertise in investigation and certification.

9-4 **MEASUREMENT SC RECOMMENDATION:** Mandate that states report child abuse and neglect fatalities to NCANDS through the state's health or public health agency utilizing a medical examiner to make the final determination. Implement newly developed standards of investigation.

THEME #10 – FEW PREVENTION AND INTERVENTION STRATEGIES HAVE BEEN PROVEN EFFECTIVE THROUGH RIGOROUS EVALUATION STUDIES.

We don't yet know which specific interventions work to prevent child abuse and neglect fatalities. There is a lack of rigorous prospective evaluation of promising strategies to identify and intervene in the highest risk families. The Commission has not found evidence of specific programs or practices proven to prevent these deaths. Although many risk and protective factors have been identified, the interaction of these factors on an individual basis has not yet been fully explored in order to accurately assess risk for specific children at specific points in time and act appropriately to protect them. Research is difficult for many reasons, but perhaps most importantly because fatalities are rare events. This makes them difficult to predict and requires that any studies include large populations. The differences in local and state definitions of child abuse and neglect fatalities, mentioned earlier, is a significant barrier to conducting the needed research.

10-1 **CPS SC RECOMMENDATION:** Congress should make submission of data to NCANDS mandatory. ACF should expand data collected by NCANDS to include more specific information about children who die from abuse or neglect whose families have history with the CPS agency. Specifically, these data should clearly identify history of screened out referrals, history of prior investigations or assessments and results, whether the case was opened for in-home services, whether the child was placed in out-of-home care, or whether the child was adopted or moved to guardianship. It also should include the status of the child at the time of death, meaning whether the child was at home in an open case, in foster care, on a trial home visit, or a former victim in a now-closed case. NCANDS should include more specific data on perpetrators, including the marital status of the caregivers at the time of the child's death.

Federal role: Create enabling legislation, collect and analyze data.

State/local role: Adapt data systems to ensure collection and reporting of all defined data elements.

10-2 **CPS SC RECOMMENDATION:** Congress should create a capacity within ACF to regularly evaluate the strength of research evidence on near fatalities and fatalities and translate this research into implications for practice.

Federal role: Create enabling legislation as needed, designate a responsible agency, collect and synthesize research, and publish results.

10-3 CPS SC RECOMMENDATION: Congress should authorize and appropriate funds to support research on the criteria associated with serious harm or death from child maltreatment and on the effectiveness of current CPS safety assessments and safety planning procedures.

Federal role: Create enabling legislation as needed, solicit research proposals, fund high-quality research efforts, and disseminate findings.

10-4 CPS SC RECOMMENDATION: Resources need to be invested in the research and development of effective interventions for families engaged with CPS who match a high-risk profile for a fatality.

Federal role: Create enabling legislation as needed, fund and manage research, and disseminate findings.

10-5 PH SC RECOMMENDATION: Test and develop the ability of home visiting to reduce child abuse and neglect fatalities. Utilize the research infrastructure through the national Home Visiting Research Network to support this effort.

10-6 RESEARCH RECOMMENDATION: Evaluate new approaches to looking at prediction and prevention of fatalities and near fatalities within communities—GIS/Risk Terrain Modeling, for example.

OTHER RECOMMENDATIONS THAT DO NOT CURRENTLY FIT UNDER ONE OF THE ABOVE THEMES

CPS SC: Congress should provide resources and pass legislation that ensures immediate access to and availability of services such as home visiting, substance abuse treatment, and mental health treatment services when a family and child are referred to CPS and a case is opened.

CPS SC: Families who are referred to CPS should be prioritized for necessary services such as child care, supportive housing, and substance abuse and mental health treatment, in order to provide additional resources to ensure child safety. Agencies should ensure adequate resources to serve these vulnerable families and children.

CPS SC: Caseloads and workload should be designed to support the level of contact with families necessary to assess the current status of a child's safety and a caregiver's progress, with intensive contacts involved in instances in which children remain at home or have been reunified. Caseloads and workloads should permit an adequate number of hours per month per family to arrange services, coach parents, support children, and participate in team meetings. Such contact could occur either by the CPS agency itself or by contract staff.

RESEARCH (Secondary prevention?): Develop clinical guidelines for specific injury situations (e.g., infant with a bruise and a fracture, child with a burn) in order to decrease missed cases of abuse in which the child goes on to have more severe injuries.